Supreme Court, U.S.
FILED
FEB 6 1998
CLERK

No. 97-156

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

RANDON BRAGDON, D.M.D.,

Petitioner,

v.

SIDNEY ABBOTT, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the First Circuit

---

BRIEF FOR AMICUS CURIAE THE ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION IN SUPPORT OF RESPONDENTS

ALTHEA GREGORY
5500 Friendship Blvd.
Chevy Chase, MD 20815
(301) 951-3602

LYNN E. CUNNINGHAM*
Associate Professor of
Clinical Law
The Jacob Burns Community
Legal Clinics
The George Washington
University Law School
2000 G Street, N.W.
Suite 200
Washington, D.C. 20052
(202) 994-7463

*Counsel of Record

Counsel for Amicus Curiae

BEST AVAILABLE COPY

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF THE AMICUS CURIAE	1
SUMMARY OF ARGUMENT	3
ARGUMENT	5
I. THE ADA WAS SPECIFICALLY INTENDED TO PREVENT THE HARMS ARISING FROM INVIDIOUS DISCRIMINATION AGAINST *ALL* THOSE INFECTED WITH HIV	5
A. The Health of the Nation's Children Would be Threatened, Contrary to Congress' Clear Intent, if the ADA Were Held to Protect Only Those With Outward Symptoms	6
B. Congress Recognized That Individuals Infected With HIV Face Invidious Discrimination Regardless of Their Stage of Life	11
II. ALL PEOPLE INFECTED WITH HIV HAVE A DISABILITY UNDER THE ADA	13
A. HIV Infection is a Physical Impairment	14
B. HIV Infection Substantially Limits the Major Life Activity of Reproduction	15
C. HIV Infection Also Substantially Limits *All* Major Life Activities, Including Living Itself	20
CONCLUSION	22

TABLE OF AUTHORITIES

	Page
CASES:	
Abbott v. *Bragdon*, 912 F. Supp. 580 (D. Me. 1995), *aff'd*, 107 F.3d 934 (1st Cir. 1997)	*passim*
Bartlett v. *New York State Bd. of Law Examiners*, 970 F. Supp. 1094 (S.D.N.Y. 1997)	16
Cain v. *Hyatt*, 734 F. Supp. 671 (E.D. Pa. 1990)	15
Chapman v. *United States*, 500 U.S. 453 (1991)	16
Chevron U.S.A. Inc. v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984)	15
District 27 Community School Bd. v. *Board of Education*, 502 N.Y.S.2d 325 (N.Y. Sup. Ct. 1986)	12-13
Doe v. *District of Columbia*, 796 F. Supp. 559 (D.D.C. 1992)	16
Doe v. *Dolton Elementary School Dist. No. 148*, 694 F. Supp. 440 (N.D. Ill. 1988)	15
Doe v. *Kohn, Nast & Graf, P.C.*, 862 F. Supp. 1310 (E.D. Pa. 1994)	16
Erickson v. *Board of Governors of State Colleges and Universities*, 911 F. Supp. 316 (N.D. Ill. 1995)	16, 18
Hernandez v. *Prudential Life Ins. Co. of America*, 977 F. Supp. 1160 (M.D. Fla. 1997)	16
Krauel v. *Iowa Methodist Medical Center*, 95 F.3d 674 (8th Cir. 1996)	16
Lowe v. *Angelo's Italian Foods, Inc.*, 87 F.3d 1170 (10th Cir. 1996)	16
Mondzelewski v. *Pathmark Stores, Inc.*, 976 F. Supp. 277 (D. Del. 1997)	16
Pacourek v. *Inland Steel Co.*, 916 F. Supp. 797 (N.D. Ill. 1996)	16

TABLE OF AUTHORITIES—Continued

	Page
Pahulu v. *University of Kansas*, 897 F. Supp. 1387 (D. Kan. 1995)	16
Purcell v. *Pennsylvania Dep't of Corrections*, 1998 WL 10236 (E.D. Pa. Jan. 9, 1998)	16
Runnebaum v. *Nationsbank of Maryland, N.A.*, 123 F.3d 156 (4th Cir. 1997) (en banc)	15
School Bd. of Nassau County v. *Arline*, 480 U.S. 273 (1987)	7
Silk v. *City of Chicago*, 1997 WL 790598 (N.D. Ill. Dec. 17, 1997)	16
Skinner v. *Oklahoma*, 316 U.S. 535 (1942)	17
Smith v. *United States*, 508 U.S. 223 (1993)	16
Stanley v. *Illinois*, 405 U.S. 645 (1972)	17
Zatarain v. *WDSU-Television, Inc.*, 881 F. Supp. 240 (E.D. La. 1995), *aff'd mem.*, 79 F.3d 1143 (5th Cir. 1996)	16
STATUTORY PROVISION:	
42 U.S.C. § 12102(2)	14
LEGISLATIVE MATERIALS:	
135 Cong. Rec. S10766 (daily ed. Sept. 7, 1989)	14
135 Cong. Rec. S10768 (daily ed. Sept. 7, 1989)	8, 14
135 Cong. Rec. S10789 (daily ed. Sept. 7, 1989)	6
136 Cong. Rec. S9527 (daily ed. Mar. 29, 1990)	14
136 Cong. Rec. H2422 (daily ed. May 17, 1990)	14
136 Cong. Rec. H2479 (daily ed. May 17, 1990)	13
136 Cong. Rec. H2480 (daily ed. May 17, 1990)	13
136 Cong. Rec. H2481 (daily ed. May 17, 1990)	13
136 Cong. Rec. S7438 (daily ed. June 6, 1990)	13
136 Cong. Rec. S9696 (daily ed. July 13, 1990)	14

TABLE OF AUTHORITIES—Continued

Page

Hearings Before the Comm. on Labor and Human Resources and the Subcomm. on the Handicapped on S. 933, 101st Cong., 1st Sess. (1989)..... 13

Hearings Before the Subcomm. on Civil and Constitutional Rights of the House Comm. on the Judiciary on H.R. 2273, 101st Cong., 1st Sess. (1989) 13

Hearings on AIDS Counseling, Testing, Confidentiality and Nondiscrimination Before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce, 100th Cong., 1st Sess. (1987)..... 10

H.R. Rep. No. 485, 101st Cong., 1st Sess., pt. 2 (1990) 6, 13

S. Rep. No. 116, 101st Cong., 1st Sess. (1990).....5, 6, 13, 19

RULE:

Sup. Ct. R. 37.6..... 1

REGULATIONS:

28 C.F.R. § 36.104..... 15

29 C.F.R. § 1630.2(i)..... 16, 20, 21

29 C.F.R. § 1630.2(j)(1) 17, 20

45 C.F.R. § 46.111(a)(4), (5)..... 10

45 C.F.R. § 46.116(a)(8)..... 10

OTHER AUTHORITIES:

Lawrence K. Altman, *Hope vs. Hype—A Special Report: With AIDS, Advance, More Disappointment*, N.Y. Times, Jan. 19, 1997 9

American Academy of Pediatrics, Provisional Committee on Pediatric AIDS, *Perinatal Human Immunodeficiency Virus Testing*, 95 Pediatrics 303 (1995) 7

F.M. Balis & David Poplack, *Drug Development and Clinical Pharmacology of Antiretroviral Drugs, in* Pediatric AIDS: The Challenge of HIV Infection in Infants, Children, and Adolescents (Philip A. Pizzo, M.D. & Catherine M. Wilfert, M.D. eds., 2d ed. 1994) 21

Huiman X. Barnhart et al., *Natural History of Human Immunodeficiency Virus Disease in Perinatally Infected Children: An Analysis from the Pediatric Spectrum of Disease Project*, 97 Pediatrics 710 (1996)..... 21

Be A Friend: Children Who Live With HIV Speak (Lori S. Weiner et al. eds., 1994) 22

Jonathon Briggs, *Parents Find Support They Can Depend On*, Ariz. Republic, Sept. 8, 1996 12

Purvette A. Bryant, *Session Focuses on Women with HIV: Physicians and Social Workers Discussed Better Ideas and Ways to Help*, Orlando Sentinel, July 27, 1996 12

Charles C.J. Carpenter et al., *Antiretroviral Therapy for HIV Infection in 1997: Updated Recommendations of the International AIDS Society—USA Panel*, 277 J. Am. Med. Ass'n 1962 (1997)..... 8

Centers for Disease Control and Prevention, *1995 Revised Guidelines for Prophylaxis Against* Pneumocystis carinii *Pneumonia for Children Infected with or Perinatally Exposed to Human Immunodeficiency Virus*, 44 Morbidity & Mortality Wkly. Rep. 1 (1995)..... 7

Centers for Disease Control and Prevention, *1998 Guidelines for Treatment of Sexually Transmit-*

TABLE OF AUTHORITIES—Continued

Page

TABLE OF AUTHORITIES—Continued

Page

ted Diseases, 47 Morbidity & Mortality Wkly. Rep. 11 (1998) 7

Centers for Disease Control and Prevention, *Public Health Service Task Force Recommendations for the Use of Antiretroviral Drugs in Pregnant Women Infected with HIV-1 for Maternal Health and for Reducing Perinatal HIV-1 Transmission in the United States*, 47 Morbidity & Mortality Wkly. Rep. 2 (1998) 9

Centers for Disease Control and Prevention, *Update: Perinatally Acquired HIV/AIDS—United States, 1997*, 46 Morbidity & Mortality Wkly. Rep. 1086 (1997) 8, 9

Clinical Trials for Asymptomatic Persons, AIDS Education Global Information System (1997) 11

Joyce Cohen et al., *School-Related Issues Among HIV-Infected Children*, 100 Pediatrics e8 (July 1997) 10

Committee on Prenatal and Newborn Screening for HIV Infection, Institute of Medicine, *HIV Screening of Pregnant Women and Newborns* (1991) 9

Edward M. Connor et al., *Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type 1 with Zidovudine Treatment*, 331 New Eng. J. Med. 1173 (1994) 8

Steven G. Deeks et al., *HIV-1 Protease Inhibitors: A Review for Clinicians*, 277 J. Am. Med. Ass'n 145 (1997) 10

Barbara Gerbert et al., *Primary Care Physicians and AIDS: Attitudinal and Structural Barriers*, 266 J. Am. Med. Ass'n 2837 (1991) 5

TABLE OF AUTHORITIES—Continued

Page

Elizabeth Glaser & Laura Palmer, *In the Absence of Angels* (1991) 12

David D. Ho, M.D., *Time to Hit HIV, Early and Hard*, 333 New Eng. J. Med. 450 (1995) 7

I Need a Friend: Kids Talk About Having the AIDS Virus (National Cancer Institute, Pediatric Branch) 12

Justice Dept. Memo on the Application of Section 504 of the 1973 Rehabilitation Act to HIV-Infected Persons, 641 Fair Empl. Prac. Cas. (BNA) at 405 (1988) 6

Charles E. Lewis & Kathleen Montgomery, *Primary Care Physicians' Refusal to Care for Patients Infected With the Human Immunodeficiency Virus*, 156 W. J. Med. 36 (1992) 5

Katherine Luzuriaga et al., *Combination Treatment with Zidovudine, Didanosine, and Nevirapine in Infants with Human Immunodeficiency Virus Type 1 Infection*, 336 New Eng. J. Med. 1343 (1997) 7

David Michaels & Carol Levine, *Estimates of the Number of Motherless Youth Orphaned by AIDS in the United States*, 268 J. Am. Med. Ass'n 3456 (1992) 18

Mireya Navarro, *Testing Newborns for AIDS Virus Raises Issue of Mothers' Privacy*, N.Y. Times, Aug. 8, 1993 9

Stephen W. Nicholas & Elaine J. Abrams, *The "Silent" Legacy of AIDS: Children Who Survive Their Parents and Siblings*, 268 J. Am. Med. Ass'n 3478 (1992) 18

Panel on Clinical Practices for Treatment of HIV Infection, *Guidelines for the Use of Antiretrovi-*

TABLE OF AUTHORITIES—Continued

	Page
ral Agents in HIV-Infected Adults and Adolescents (1997)	7
Elizabeth Pennisi & Kathy A. Fackelmann, *HIV Toll: Over a Billion White Cells a Day; Virus Overwhelms CD4 T-*Cells, 147 Science News 21 (1995)	15
Report of Presidential Commission on the Human Immunodeficiency Virus Epidemic (1988)	5
Rhonda S. Sperling at al., *Maternal Viral Load, Zidovudine Treatment, and the Risk of Transmission of Human Immunodeficiency Virus Type 1*, 335 New Eng. J. Med. 1621 (1996)	8
Suits Say Child with HIV Denied Admission to Day Care Centers, Disability Compliance Bulletin (July 31, 1997)	12
James Tobin, *The Neglected Victims: More Females Fall to Deadly Affliction: Lack of Studies on Women Slows Treatment*, Det. News, Dec. 28, 1997	10
Webster's Third New International Dictionary (1976)	17
Working Group on Antiretroviral Therapy and Medical Management of HIV Infected Children, *Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection* (1997)	7

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

No. 97-156

RANDON BRAGDON, D.M.D.,

Petitioner,

v.

SIDNEY ABBOTT, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the First Circuit

---

BRIEF FOR AMICUS CURIAE THE ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION IN SUPPORT OF RESPONDENTS

INTEREST OF THE AMICUS CURIAE

The Elizabeth Glaser Pediatric AIDS Foundation (the "Foundation") identifies, funds, and conducts research into the human immunodeficiency virus ("HIV") particularly as it affects the health of children.[1] The Foundation has a three-

---

[1] Pursuant to Supreme Court Rule 37.6, amicus states that no counsel for a party authored this brief in whole or in part and no person, other than amicus or its counsel, made a monetary contribution to the preparation or submission of the brief. This brief is submitted with the consent of all of the parties, whose letters of consent have been lodged with the Clerk.

fold mission: to develop therapies preventing transmission of HIV from an infected mother to her newborn; to prolong and improve the lives of children with HIV; and to eliminate HIV in infected children. To date, the Foundation has raised nearly $60,000,000 in support of pediatric HIV and AIDS research. It has funded over two hundred research grants, several long-term clinical studies, and emergency assistance programs for pediatric AIDS patients and HIV-positive pregnant women in hospitals across the country, and it has played a primary role in educating the public about HIV and AIDS, including conducting national campaigns encouraging pregnant women to be tested for the virus.

The Foundation wishes to apprise the Court of the significance of this case for a group often ignored in the current debate over the reach of the Americans with Disabilities Act ("ADA")—the thousands of children who are infected with HIV, and those children not yet born who are at risk of contracting the disease from infected mothers. AIDS is the seventh-leading cause of death for children under four years of age in the United States. Nearly all children infected with the virus acquire it from their mothers *in utero* or during childbirth. As of 1997, between ten and twenty thousand children were estimated to be infected with HIV themselves. Over forty thousand children, many of them uninfected, had lost one or both of their parents to AIDS by that time.

The Foundation, and those whose interests it advocates, have a substantial interest in this case. As Congress recognized in enacting the ADA, fear of discrimination can deter people infected with HIV (including pregnant women) from seeking critical early testing, counseling, and treatment—*before* outward symptoms arise—that would in many cases prevent children from ever acquiring the disease. Moreover, when children do contract HIV, they, like their adult counterparts, face severe discrimination on the basis of that status. Thus, it is of vital importance to the lives of many of the Nation's children that the Court confirm Congress' intent that *all* individuals with HIV—regardless of visible symptoms or stage of life—be protected from invidious discrimination.

SUMMARY OF ARGUMENT

When it enacted the ADA, Congress specifically intended to protect all HIV-infected individuals from invidious discrimination, in part to ensure that the fear of such discrimination would not deter these people from seeking needed testing and treatment. This public health goal would be severely compromised if the Act were interpreted to protect only those who have manifested outward symptoms of the infection. Indeed, it is now even more imperative that individuals without visible symptoms of infection receive the protection Congress intended, for it is at that early stage of the disease that treatments are most effective.

Such protection is particularly important to the health and well-being of the Nation's children. Clinical studies have shown that treatment of an HIV-positive pregnant woman before major symptoms arise greatly reduces the likelihood that her child will contract the virus. This research showed a nearly two-thirds reduction in the transmission of the virus from mother to infant. In practice, three years after the research study concluded, transmission from mothers to children has been dramatically reduced in the United States as pregnant women have been offered counseling, testing, and treatment. This will save the lives of thousands of children. A decision legitimizing discrimination against HIV-positive individuals without visible symptoms would slow that progress considerably by deterring individuals from seeking needed testing and treatment and participating in critical research, all contrary to Congress' clear intent.

In addition, in enacting the ADA Congress specifically intended to protect all HIV-infected individuals from discrimination on the basis of that status, regardless of their particular stage of life. For example, Congress was concerned about, and intended to prohibit, invidious discrimination against children with HIV, which Congress recognized as a serious problem. Indeed, before enactment of the ADA, HIV-infected children received protection under earlier anti-discrimination laws even before their adult counterparts. It

would completely subvert Congress' intent to now legitimize discrimination against these children.

The language of the ADA and its implementing regulations establish that individuals with HIV, but without visible symptoms, are covered by the statute. As is true with all individuals infected with this fatal virus, whether showing external symptoms or not, major life activities of HIV-infected children—indeed, their very lives—are substantially limited as a result of their condition. Under the statutory language, HIV is a "physical impairment," and reproduction (necessarily including conception, pregnancy, delivery, and child-rearing) is a "major life activity" that is "substantially limited" by that impairment. This is so for *all* individuals with HIV. Congress intended to extend the ADA's protection to all those with physical impairments, like HIV, that are so severe that they will limit a major life activity as compared with the general population. Moreover, HIV is a fatal, incurable condition that significantly reduces one's life expectancy. Accordingly, HIV meets the statutory definition of a disability because it substantially limits *all* major life activities—indeed, life itself.

The Foundation therefore urges the Court to uphold the decision below and make clear that all persons with HIV, whether exhibiting visible symptoms or not, adults or children, are protected under the ADA. To hold otherwise would relegate infected children and adults who have not yet developed outward symptoms to a second-class status and permit discrimination precisely when medicine and public health most need it to be prevented. If the ADA is to achieve its ultimate purpose, it must ensure that all people who suffer from this stigmatizing fatal disease will not face invidious discrimination as a result of that disability.[2]

---

[2] This brief focuses on the first two questions presented in the Court's grant of certiorari. The Foundation, however, also supports respondent's position on the third question presented: that there should be a presumption in favor of universal expert and professional standards when evaluating whether a patient presents a "direct threat" under the ADA. Such an interpretation is critically important in ensuring proper medical care for children and others infected with HIV, as studies have shown that many health care providers would refuse to treat HIV-infected individuals if given the choice. *See* Barbara Gerbert et al., *Primary Care Physicians and AIDS: Attitudinal and Structural Barriers*, 266 J. Am. Med. Ass'n 2837, 2841 (1991); Charles E. Lewis & Kathleen Montgomery, *Primary Care Physicians' Refusal to Care for Patients Infected With the Human Immunodeficiency Virus*, 156 W. J. Med. 36, 37 (1992).

ARGUMENT

I. THE ADA WAS SPECIFICALLY INTENDED TO PREVENT THE HARMS ARISING FROM INVIDIOUS DISCRIMINATION AGAINST *ALL* THOSE INFECTED WITH HIV

The purpose of the ADA was simple: "to provide a clear and comprehensive national mandate to end discrimination against individuals with disabilities and to bring persons with disabilities into the economic and social mainstream of American life." S. Rep. No. 116, 101st Cong., 1st Sess. 2 (1990). To accomplish this purpose, Congress prohibited discrimination against all individuals with physical impairments so severe that the individuals were, in Congress' view, likely to be the targets of invidious discrimination that would prevent them from being integrated into the mainstream of American life.

This goal will be thwarted if the ADA is construed to protect HIV-infected individuals only when they presently experience outward symptoms. Rather, in order to ensure that persons with HIV are incorporated into the mainstream of society and are not deterred from seeking vital testing and treatment, Congress specifically intended to prohibit invidious discrimination against *all* individuals infected with this fatal disease—whether outwardly manifesting symptoms or not, children or adults.

A. The Health of the Nation's Children Would be Threatened, Contrary to Congress' Clear Intent, if the ADA Were Held to Protect Only Those With Outward Symptoms

Congress recognized that the harm it sought to prohibit through the ADA—specifically including discrimination against HIV-infected individuals—has wide-ranging effects on both the person with the disability and society at large. In describing the nature and extent of the problem it sought to combat, Congress expressly noted that "discrimination against individuals with HIV infection is widespread and has serious repercussions for both the individual who experiences it and for the Nation's efforts to control the epidemic." *Id.* at 8. Both houses of Congress thus endorsed the conclusions of a presidential report that:

> "As long as discrimination occurs, and no strong national policy with rapid and effective remedies against discrimination is established, individuals who are infected with HIV will be reluctant to come forward for testing, counseling, and care. This fear of potential discrimination * * * will undermine our efforts to contain the HIV epidemic and will leave HIV-infected individuals isolated and alone."

Id. at 8 (quoting *Report of Presidential Commission on the Human Immunodeficiency Virus Epidemic* 119 (1988)); H.R. Rep. No. 485, 101st Cong., 1st Sess., pt. 2 at 31 (1990).[3] In recognizing this fact, Congress simply echoed this Court's understanding that protection against disability discrimination "will assist local health officials by helping remove an important obstacle to preventing the spread of infectious diseases: the individual's reluctance to report his or her condition." *School Bd. of Nassau County* v. *Arline*, 480 U.S. 273, 286 n.15 (1987).

In light of Congress' intended purpose of containing the epidemic by removing the obstacles to testing and treatment caused by discrimination, it is essential that the protection of the ADA be afforded to individuals who have not yet begun to experience the outward symptoms of the disease. For it is at this stage that testing, treatment, and research are increasingly most effective. The scientific evidence is clear that to be most effective, monitoring and treatment for HIV must begin long before any visible symptoms arise.[4] Recent guidelines for adults and children emphasize the importance of early identification of HIV infection through testing. These guidelines make clear that early diagnosis *before* external symptoms develop, and regular monitoring thereafter, are important to determining when to begin antiretroviral therapy as well as treatments to prevent opportunistic infections.[5] To hold that the ADA applies only to a narrow

---

[3] *See also* 135 Cong. Rec. S10789 (daily ed. Sept. 7, 1989) ("By barring discrimination based on HIV infection, we clear the path not only to voluntary AIDS testing and counseling—but also to appropriate medical treatment that benefits the individual patient.") (statement of Sen. Kennedy); *Justice Dept. Memo on the Application of Section 504 of the 1973 Rehabilitation Act to HIV-Infected Persons*, 641 Fair Empl. Prac. Cas. (BNA) at 405 (1988) (statement of Surgeon General C. Everett Koop, M.D. that, for counseling and testing to be most effective, "individuals must have confidence that they will be protected fully from HIV related discrimination").

[4] *See* Katherine Luzuriaga et al., *Combination Treatment with Zidovudine, Didanosine, and Nevirapine in Infants with Human Immunodeficiency Virus Type 1 Infection*, 336 New Eng. J. Med. 1343 (1997); Centers for Disease Control and Prevention, *1995 Revised Guidelines for Prophylaxis Against* Pneumocystis carinii *Pneumonia for Children Infected with or Perinatally Exposed to Human Immunodeficiency Virus*, 44 Morbidity & Mortality Wkly. Rep. 1, 5-6 (1995); David D. Ho, M.D., *Time to Hit HIV, Early and Hard*, 333 New Eng. J. Med. 450 (1995); American Academy of Pediatrics, Provisional Committee on Pediatric AIDS, *Perinatal Human Immunodeficiency Virus Testing*, 95 Pediatrics 303, 304 (1995).

[5] *See* Centers for Disease Control and Prevention, *1998 Guidelines for Treatment of Sexually Transmitted Diseases*, 47 Morbidity & Mortality Wkly. Rep. 11 (1998); Working Group on Antiretroviral Therapy and Medical Management of HIV Infected Children, *Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection* 4 (1997) <http://www.hivatis.org/revpedgu.html>; Panel on Clinical Practices for Treatment of HIV Infection, *Guidelines for the Use of Antiretroviral Agents in HIV-*

category of infected individuals—those with visible symptoms—would be to withhold protection from discrimination precisely where it is increasingly needed most.[6]

Perhaps nowhere is Congress's goal of removing obstacles to early testing and treatment more important than in protecting the health of the Nation's children. An important study, completed in 1994, examined the effect of drug therapy on the transmission of HIV from pregnant mothers to their children. The study involved pregnant women with HIV who did not have AIDS and, according to the standards of the time, did not require antiretroviral therapy such as the drug zidovudine ("AZT") to maintain their own health. The study discovered that administering AZT to these pregnant women reduced transmission of HIV from pregnant mother to child by nearly two-thirds—from 23% to only 8%.[7] As a result of this research, the number of perinatally-acquired AIDS cases dropped by a staggering 43% between 1992 and 1996—perhaps the greatest preventive advance since the advent of the HIV epidemic. *See* Centers for Disease Control and Prevention, *Update: Perinatally Acquired HIV/AIDS—United States, 1997*, 46 Morbidity & Mortality Wkly. Rep. 1086,

Infected Adults and Adolescents 5 (1997) <http://www.hivatis.org/upguidaa.html.>; Charles C.J. Carpenter et al., *Antiretroviral Therapy for HIV Infection in 1997: Updated Recommendations of the International AIDS Society—USA Panel*, 277 J. Am. Med. Ass'n 1962 (1997).

[6] *See* 135 Cong. Rec. S10768 (daily ed. Sept. 7, 1989) (in light of evidence that AZT is helpful for "those that have tested positive but do not have the disease," "if you are going to encourage individuals to come forward for counseling and testing and crucial medical care—if you are going to get them to go out and pursue voluntary testing, we must not limit their protection under this act") (statement of Sen. Kennedy).

[7] *See* Edward M. Connor et al., *Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type 1 with Zidovudine Treatment*, 331 New Eng. J. Med. 1173, 1178 (1994); Rhonda S. Sperling et al., *Maternal Viral Load, Zidovudine Treatment, and the Risk of Transmission of Human Immunodeficiency Virus Type 1*, 335 New Eng. J. Med. 1621, 1622-23 (1996).

1088 (1997). The dramatic decline in perinatally-acquired AIDS is believed to be indicative of the effectiveness of AZT in reducing perinatal HIV transmission. *Id.* at 1089. Current guidelines recommend that all pregnant women with HIV be offered AZT, and advised about its utility in reducing transmission, early in the pregnancy.[8]

Perinatal transmission of HIV, however, can only be prevented if pregnant women are willing to be tested and treated. Yet public health officials and others have recognized (as did Congress in enacting the ADA) that pregnant women may fail to be tested for HIV due to fear of discrimination. *See* Committee on Prenatal and Newborn Screening for HIV Infection, Institute of Medicine, *HIV Screening of Pregnant Women and Newborns*, App. A, at 124 (1991) (conference summary noting that to avoid discrimination, "some pregnant women refuse to be tested"); Mireya Navarro, *Testing Newborns for AIDS Virus Raises Issue of Mothers' Privacy*, N.Y. Times, Aug. 8, 1993, at 1 ("[S]ome women refuse to take the [HIV] test even when reached by H.I.V. counselors, fearing that they would lose their children or suffer discrimination if the test indicated infection."). If pregnant women are less willing to come forward for fear of discrimination against themselves or their children, thousands of children will unnecessarily be infected with HIV and die.

In addition, fear of discrimination can also affect treatment once it has begun. The efficacy of current treatment regimens depends on medications being administered virtually around-the-clock.[9] If individuals are unwilling to take these

[8] Centers for Disease Control, *Public Health Service Task Force Recommendations for the Use of Antiretroviral Drugs in Pregnant Women Infected with HIV-1 for Maternal Health and for Reducing Perinatal HIV-1 Transmission in the United States*, 47 Morbidity & Mortality Wkly. Rep. 2, 2-14 (1998).

[9] Current treatment regimens are extremely complex, requiring individuals to take dozens of pills each day and at many different times during the day. Lawrence K. Altman, *Hope vs. Hype—A Special Report; With AIDS, Advance, More Disappointment*, N.Y. Times, Jan. 19, 1997, at 1.

medications in public settings, such as school or the workplace, due to fear of discrimination, their treatment will be compromised, which could in turn result in a resistant strain of the virus. *See, e.g.*, Joyce Cohen et al., *School-Related Issues Among HIV-Infected Children*, 100 Pediatrics e8 (July 1997) <http://www.pediatrics.org/cgi/content/full/100/1/38> (reporting case of child who hid in school bathroom to take his medications in order to hide HIV status from school nurse); Steven G. Deeks et al., *HIV-1 Protease Inhibitors: A Review for Clinicians*, 277 J. Am. Med. Ass'n 145 (1997) (indicating that failure to maintain a strict drug regimen can lead to drug-resistant strains of HIV).

Failure to protect people without visible symptoms of their HIV infection from discrimination will likewise have adverse effects on vital research into the causes and treatment of HIV and AIDS. Such research depends entirely on the participation of volunteers. *See, e.g.*, 45 C.F.R. §§ 46.111(a)(4), (5); 45 C.F.R. § 46.116(a)(8). Public health would thus be jeopardized if the law provides no protection from discrimination based on HIV status, as people would be less willing to come forward to participate in research.[10] As with the study of perinatal transmission noted above, much of the most important research today involves individuals without

[10] *See Hearings on AIDS Counseling, Testing, Confidentiality and Nondiscrimination Before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce*, 100th Cong., 1st Sess. 1 (1987) (lack of nondiscrimination provisions threatens "the Nation's ability to study and understand the [HIV] epidemic. What we know about the disease we know because people have volunteered to cooperate with research efforts. If misguided testing policies drive these people away, it will only prolong the epidemic.") (statement of Rep. Waxman); James Tobin, *The Neglected Victims: More Females Fall to Deadly Affliction: Lack of Studies on Women Slows Treatment*, Det. News, Dec. 28, 1997, at A1 (many women "are reluctant to join a research study for fear of revealing their infection to employers, friends, even family members").

visible symptoms—the very people who would lack protection if petitioner were to prevail here.[11]

At a time when the most effective HIV treatments, and the most important research, increasingly involve individuals *without* visible symptoms, it is essential that these people not be deterred from coming forward. Until now, pregnant women and others who suspected they might be infected could reasonably believe, based on Congress' clear intent and the virtually uniform case law in the area, that they would not face discrimination based on their HIV status. If the Court now decides that such discrimination is lawful until external symptoms appear, these individuals would be forced to choose between being tested for the presence of a virus that is invariably fatal, and the potential loss of housing, employment, day care, schooling, medical care, and other necessary services. As Congress itself concluded, the failure to protect HIV-positive individuals without visible symptoms from discrimination will deter them from ascertaining their own HIV-status, complying with suggested treatments, and participating in critical research. It would therefore be a legal irony, a medical anomaly, and a threat to public health—particularly that of the Nation's children—to hold that the ADA protects HIV-infected individuals only when their disease has manifested itself with outward symptoms.

B. Congress Recognized That Individuals Infected With HIV Face Invidious Discrimination Regardless of Their Stage of Life

Just as Congress' public health goals would be compromised if the ADA's protection were limited only to individuals with outward symptoms, so too its goal of incorporating all those with HIV into the mainstream of society would be thwarted if protection were limited, as petitioner suggests, only to "women of childbearing age." Pet. Br. 13. Congress

[11] *See Clinical Trials for Asymptomatic Persons, AIDS Education Global Information System* (1997) <http://www.aegis.com/aegis/trials/asymptomatic.htm> (listing clinical trials of therapies and vaccines for people with asymptomatic HIV infection).

was concerned about preventing invidious discrimination against *all* individuals infected with the virus, specifically including children.

All persons with HIV, whether exhibiting visible symptoms or not, children or adults, experience invidious discrimination on account of that physical impairment. Unfortunately, discrimination against HIV-infected children has been, and continues to be, a particular problem. For example, a family in Florida with infected children received death threats and their house was burned in an attempt to keep the children from attending school.[12] An infected child was sprayed with bleach after sneezing in her kindergarten classroom.[13] Day care centers and schools still turn away children who are HIV-positive.[14] And the late Elizabeth Glaser, co-founder of the Foundation, concealed the fact that her children were infected with the virus, for fear of discrimination against them in school, recreation, and daily life.[15]

The earliest cases involving discrimination against HIV-infected individuals were filed by children against their schools under the Rehabilitation Act of 1973, whose definition of disability was adopted in the ADA. In one of the first of these cases, a child with HIV was held to be disabled under the Rehabilitation Act. *See District 27 Community*

---

[12] *See* Elizabeth Glaser & Laura Palmer, *In the Absence of Angels* 59-60 (1991) [hereinafter "Glaser & Palmer"].

[13] *See I Need a Friend: Kids Talk About Having the AIDS Virus* (National Cancer Institute, Pediatric Branch) (videotape on file with the Elizabeth Glaser Pediatric AIDS Foundation).

[14] *See Suits Say Child with HIV Denied Admission to Day Care Centers*, Disability Compliance Bulletin 11 (July 31, 1997); Jonathon Briggs, *Parents Find Support They Can Depend On*, Ariz. Republic, Sept. 8, 1996, at F10 (HIV-positive women and children face problems obtaining child care); Purvette A. Bryant, *Session Focuses on Women with HIV; Physicians and Social Workers Discussed Better Ideas and Ways to Help*, Orlando Sentinel, July 27, 1996, at C1 (women with HIV commonly face problems with housing, child care, transportation, and day care).

[15] *See* Glaser & Palmer, *supra* note 12, at 50-51, 53, 61-62.

School Bd. v. *Board of Educ.*, 502 N.Y.S.2d 325, 336 (N.Y. Sup. Ct. 1986). Congress specifically sought to continue this protection when it enacted the ADA. The Act's legislative history demonstrates that Congress was deeply concerned about discrimination against HIV-positive children, whether visibly symptomatic or not. The committee hearings and floor debates are replete with references to children afflicted with HIV, especially Ryan White, a child with HIV who was barred from school and whose crusade against discrimination brought him national attention and admiration before his death from AIDS.[16]

It would subvert Congress' intent if children infected with HIV—who were protected from discrimination under judicial interpretations of federal anti-discrimination laws long before their adult counterparts—now found themselves stripped of that protection. HIV is a serious, stigmatizing impairment regardless of one's symptomatic status or stage of life, and the protection of the ADA should extend equally to *all* individuals with that disability.

II. ALL PEOPLE INFECTED WITH HIV HAVE A DISABILITY UNDER THE ADA

Congress' intended goal of eliminating discrimination against all persons infected with HIV is readily apparent from the text of the ADA, its implementing regulations, and its legislative history.[17] In the ADA, Congress broadly prohib-

---

[16] *See, e.g.*, 136 Cong. Rec. H2479 (daily ed. May 17, 1990) (statement of Rep. McCloskey); *id.* at H2480 (statement of Rep. McDermott); *id.* at H2481 (statement of Rep. Jontz); *id* at S7438 (daily ed. June 6, 1990) (statement of Sen. Harkin); *Hearings Before the Comm. on Labor and Human Resources and the Subcomm. on the Handicapped on S. 933*, 101st Cong., 1st Sess. 102 (1989); *Hearings Before the Subcomm. on Civil and Constitutional Rights of the House Comm. on the Judiciary on H.R. 2273*, 101st Cong., 1st Sess. 171 (1989).

[17] The legislative history of the ADA is unequivocal that members of Congress—both supporters and opponents of the Act—as well as the President understood and recognized that all individuals with HIV be protected. *See, e.g.*, H.R. Rep. No. 485, 101st Cong., 1st Sess., pt. 2 at 52 ("a person infected with the Human

ited discrimination against any person with a physical impairment that "substantially limits" one or more "major life activities." 42 U.S.C. § 12102(2). HIV, whether visibly symptomatic or not, is plainly a physical impairment that substantially limits major life activities. There is no dispute that HIV infection is, in every affected person, a physical impairment of the hemic and lymphatic systems. And, whether visibly symptomatic or not, HIV infection substantially limits not only the major life activity of reproduction, as the Court of Appeals found, but indeed *all* major life activities, because the virus substantially limits life itself.

A. HIV Infection is a Physical Impairment

HIV infection is plainly a "physical impairment" within the meaning of the statute, and petitioner does not argue otherwise. When HIV first enters the bloodstream, it immediately

---

Immunodeficiency Virus is covered under the first prong of the definition of the term 'disability' because of a substantial limitation to procreation and intimate sexual relationships"); S. Rep. No. 116, 101st Cong., 1st Sess. at 22 ("[A] person infected with the Human Immunodeficiency Virus is covered under the first prong of the definition of the term 'disability.'"); 135 Cong. Rec. S10768 (daily ed. Sept. 7, 1989) ("[W]e have pointed out very clearly, if you are asymptomatic and HIV-positive, you are protected; if you have full-blown AIDS, you are protected.") (statement of Sen. Kennedy); 136 Cong. Rec. S9696 (daily ed. July 13, 1990) (ADA covers "individuals who have any condition along the full spectrum of HIV infection") (statement of Sen. Kennedy); 136 Cong. Rec. H2422 (daily ed. May 17, 1990) ("With this bill * * * if it is adopted, every HIV carrier in the country immediately comes within the definition of a disabled person") (statement of Rep. Dannemeyer); 135 Cong. Rec. S10766 (daily ed. Sept. 7, 1989) ("those who are HIV positive * * * are covered") (statement of Senator Helms); 135 Cong. Rec. S10768 (daily ed. Sept. 7, 1989) ("I am talking about those who are HIV positive. You include them as handicapped * * *.") (statements of Sen. Helms); 136 Cong. Rec. S9527 (daily ed. Mar. 29, 1990) ("Our goal is to turn irrational fear into rational acts. * * * I call on Congress to get on with the job of passing a law—as embodied in the Americans with Disabilities Act—that prohibits discrimination against those with HIV and AIDS.") (statement of President Bush).

begins attacking and disabling white blood cells, which normally control infections in the body. The virus is never dormant. During the so-called "asymptomatic" period, the virus multiplies at a rate of a billion particles per day, and actively invades, infects, and kills the body's immune system cells. Elizabeth Pennisi & Kathy A. Fackelmann, *HIV Toll: Over a Billion White Cells a Day: Virus Overwhelms CD4 T-Cells*, 147 Science News 21 (1995). It continues to reproduce, "wearing away at the immune system" until the final, fatal stages of the disease. *Runnebaum* v. *Nationsbank of Maryland, N.A.*, 123 F.3d 156, 180 (4th Cir. 1997) (en banc) (Michael, J., dissenting).

The ADA's implementing regulations, which receive deference unless they are "arbitrary, capricious, or manifestly contrary to the statute," *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984), define a "physical impairment" as, among other things, "any physiological disorder or condition * * * affecting * * * [the] hemic and lymphatic" systems. 28 C.F.R. § 36.104. The decimation of the white blood cells and lymphocytes by the virus clearly is a disorder affecting the hemic and lymphatic systems. *See Runnebaum*, 123 F.3d at 180 (Michael, J., dissenting); *Cain* v. *Hyatt*, 734 F. Supp. 671, 679 (E.D. Pa. 1990); *Doe* v. *Dolton Elem. School Dist. No. 148*, 694 F. Supp. 440, 444 (N.D. Ill. 1988). Further, the regulations themselves state that "HIV disease (whether symptomatic or asymptomatic)" is an impairment under the statute. 28 C.F.R. § 36.104. *See Abbott* v. *Bragdon*, 107 F.3d 934, 939 (1st Cir. 1997) (holding "unhesitatingly that HIV-positive status, whether symptomatic or asymptomatic, comprises a physical impairment under the ADA").

B. HIV Infection Substantially Limits the Major Life Activity of Reproduction

The Court of Appeals held, as have many other courts, that HIV infection "substantially limits" the "major life activity"

of "reproduction."[18] This Court should affirm that holding. Reproduction, and the "bundle of activities" that term encompasses, *Abbott*, 107 F.3d at 941, is a major life activity within the meaning of the ADA, and one that is substantially limited by HIV infection.

Neither the statute nor its implementing regulations set forth all possible "major life activities." The ADA's implementing regulations cite examples of major life activities as including "functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 29 C.F.R. § 1630.2(i). The list is nonexclusive, however, and courts have found myriad other functions to be major life activities.[19] Thus, because there is no exhaustive definition of the statutory term, it must be construed "in accord[ance] with its ordinary or natural meaning." *Smith* v. *United States*, 508 U.S. 223, 228 (1993); *see also Chapman* v. *United States*, 500 U.S. 453, 462 (1991). The dictionary defines "major" as "greater in dignity, rank, importance, or interest: superior." *Webster's Third New International Dictionary* 1363 (1976); *see also Abbott*, 107 F.3d at 939 (plain meaning of the word "major" denotes "comparative importance"). Under the term's ordinary meaning, reproduction is a "major" life activity. Conceiving and bearing a child, and raising that child into an adult, are "greater in dignity, rank, importance [and] interest" than virtually any other human function, for bearing and rearing children ensures the continued existence of our species. *See Stanley* v. *Illinois*, 405 U.S. 645, 651 (1972) (rights to conceive and raise one's children are "basic civil rights of man") (quoting *Skinner* v. *Oklahoma*, 316 U.S. 535, 541 (1942)).

[18] *See Abbott*, 107 F.3d at 939; *Hernandez* v. *Prudential Life Ins. Co. of Amer.*, 977 F. Supp. 1160, 1163 (M.D. Fla. 1997); *Pacourek* v. *Inland Steel Co.*, 916 F. Supp. 797, 804 (N.D. Ill. 1996); *Erickson* v. *Board of Govs. of State Colleges and Univs.*, 911 F. Supp. 316, 323 (N.D. Ill. 1995); *Doe* v. *Kohn, Nast & Graf*, 862 F. Supp. 1310, 1320 (E.D. Pa. 1994); *Doe* v. *District of Columbia*, 796 F. Supp. 559, 568 (D.D.C. 1992); *Cain*, 734 F. Supp. at 679. The First Circuit properly rejected the contrary view. *See Krauel* v. *Iowa Methodist Med. Ctr.*, 95 F.3d 674 (8th Cir. 1996); *Zatarain* v. *WDSU-Television, Inc.*, 881 F. Supp. 240, 243 (E.D. La. 1995), *aff'd mem.*, 79 F.3d 1143 (5th Cir. 1996).

[19] *See, e.g., Lowe* v. *Angelo's Italian Foods, Inc.*, 87 F.3d 1170, 1174 (10th Cir. 1996) (lifting); *Purcell* v. *Pennsylvania Dep't of Corrections*, 1998 WL 10236 at *8 (E.D. Pa. Jan. 9, 1998) ("communicat[ing] with others for extended periods of time"); *Mondzelewski* v. *Pathmark Stores, Inc.*, 976 F. Supp. 277, 279 (D. Del. 1997) (lifting and reaching); *Bartlett* v. *New York State Bd. of Law Examiners*, 970 F. Supp. 1094, 1117 (S.D.N.Y. 1997) (reading and writing); *Pahulu* v. *University of Kansas*, 897 F. Supp. 1387, 1391 (D. Kan. 1995) (interscholastic sports); *Silk* v. *City of Chicago*, 1997 WL 790598 at *7 (N.D. Ill. Dec. 17, 1997) (sleep).

There is likewise no question that HIV infection substantially limits this major life activity. Under the ADA's regulations, a "substantial limitation" is defined as either being "[u]nable to perform a major life activity that the average person in the general population can perform" or being "*[s]ignificantly restricted* as to the condition, manner or duration under which an individual can perform a particular major life activity" as compared to the average person in the general population. 29 C.F.R. § 1630.2(j)(1)(i), (ii). While HIV does not necessarily render infected individuals "unable" to reproduce or engage in intimate sexual activity, the virus "[s]ignificantly restricts" their ability to do so. HIV-positive men and women risk infecting their partners if they engage in intimate sexual activity. HIV-positive women who become pregnant also face an unacceptable risk of infecting their children.[20] Should they survive to puberty, children who are perinatally infected will confront all the reproductive limitations that adults do; but

[20] As noted above, if an HIV-positive woman becomes pregnant, chances are one in four that her child will also be infected, a risk that drops, but only to 8%, with AZT treatment. *See supra* at 8. As the Court of Appeals held, "no reasonable juror could conclude that an 8% risk of passing an incurable, debilitating, and inevitably fatal disease to one's child is not a substantial restriction on reproductive activity." *Abbott*, 107 F.3d at 942.

the harsh fact is that most will not survive to bear children and raise them.[21]

As the courts below found, moreover, reproduction does not just encompass conception, gestation, and childbirth. It includes as well "the process of raising and caring for offspring." *Abbott* v. *Bragdon*, 912 F. Supp. 580, 586 (D. Me. 1995); *see also Abbott*, 107 F.3d at 941; *Erickson*, 911 F. Supp. at 322. HIV-positive parents (whether natural, foster, or adoptive) are substantially limited in their ability to rear their children. To this point, HIV infection is invariably and inevitably fatal. Because the life expectancy of an HIV-positive parent is far shorter than average, that parent's ability to raise his or her child to adulthood is substantially restricted. This impact of HIV infection on families, and on the lives of children of HIV-positive parents, is far from hypothetical. It is estimated that more than forty thousand children have already lost one or both parents to AIDS, and that, by the turn of the century, the number of children orphaned by AIDS in the United States alone will exceed eighty thousand.[22]

Importantly, HIV results in a substantial limitation of the major life activity of reproduction regardless of one's particular stage in life. In the ADA, Congress broadly prohibited discrimination against any person with a physical impairment that "substantially limits" one or more "major life activities." Congress prohibited such discrimination regardless of whether the specific life activity limited by the disability has any relation to the discriminatory act. For example, it would be unlawful for the petitioner in this case arbitrarily to refuse to

---

[21] The shortened life expectancy of children should itself be considered a limitation on the major life activity of reproduction. *See infra* at 20-22.

[22] *See* Stephen W. Nicholas & Elaine J. Abrams, *The "Silent" Legacy of AIDS: Children Who Survive Their Parents and Siblings*, 268 J. Am. Med. Ass'n 3478, 3478 (1992); David Michaels & Carol Levine, *Estimates of the Number of Motherless Youth Orphaned by AIDS in the United States*, 268 J. Am. Med. Ass'n 3456, 3458 (1992).

treat a blind person on the basis of that disability, regardless of whether he viewed blindness as having anything to do with dental treatment. Likewise, one cannot discriminate against a person with AIDS (a conceded disability) regardless of whether the discrimination has anything to do with the major life activities limited by that disease, or whether the discriminatory actor even knew of those limitations. The statutory definition was thus intended to denote those disabilities that are sufficiently serious to become the target of irrational animus, regardless of whether the animus is predicated on the limitations caused by the disability. *See* S. Rep. No. 116, 101st Cong., 1st Sess. at 23 (1990) (definition of disability intended as a means of excluding "[p]ersons with minor, trivial impairments").

These policies would not be served if the ADA's protection were extended only to a narrow class of individuals infected with HIV. Reproduction is a major life activity within the meaning of the ADA notwithstanding that it occurs, at most, only several times in an average person's life. It would be patently absurd, and would not comport with Congress' intent, to hold that the Act protects only those HIV-infected individuals who have the subjective intent of engaging in reproductive activities in the imminent future. Both children and adults with HIV have the same physical impairment, the impairment limits the potential reproductive activities of both groups in the same manner—regardless of their immediate subjective intentions—and both groups experience the same sort of invidious discrimination. There is no reason to conclude that the disease affects the lives of children less severely than those of adults.[23]

---

[23] Under a restrictive definition of "reproduction" as affecting only those presently able to bear or raise children, a thirteen-year-old, HIV-positive girl who reaches puberty would, for a reason wholly unrelated to her illness, attain the ranks of the "disabled" subclass of HIV-infected people. Her friend of the same age who has not yet reached puberty, but who is also HIV-positive, would not be disabled and would be unprotected from discrimination based on her HIV status. Congress could not have intended such an arbitrary and irrational result.

The ADA was intended to cover disabilities, like HIV, which are so severe that by their very nature they substantially limit a major life activity of human beings. Because the virus can be transmitted to partners and children and because it invariably causes debilitation and eventually death, HIV infection necessarily results in a substantial limitation on reproductive activities as compared to the general population.[24] Children with HIV should not be excluded from the protections of the statute merely because they are not yet grown, a reason completely divorced from their fatal impairment or the discrimination it engenders.

C. HIV Infection Also Substantially Limits *All* Major Life Activities, Including Living Itself

The Court, however, should not focus narrowly on HIV's effect on the major life activity of reproduction. The virus, because it is invariably fatal, radically foreshortens an infected person's life span. Accordingly, HIV "substantially limits" *all* the "major life activities" of every infected person, because it substantially limits life itself.

Under the implementing regulations, a physical impairment is "substantially limiting" if, among other things, it significantly restricts the condition, manner or *duration* within which an individual can perform a major life activity. 29 C.F.R. § 1630.2(j)(1)(ii). As a matter of plain language, there can be no doubt that living itself is a "major life activity"—indeed, living and life activity are synonymous terms. There can also be no doubt that, for all HIV-infected individuals, the duration of their lives—and therefore the duration, condition and manner within which they can perform *all* major life activities—are substantially limited when compared to the general population. Compared to the duration,

[24] That is not the case for all physical impairments that affect major life activities. Certain impairments, like arthritis, may substantially limit major life activities of some people but may simply be a minor irritant for others. In such circumstances—unlike the necessarily substantial effect of HIV on reproduction—the severity of a physical impairment can only be judged by its effects in a particular factual setting.

condition and manner within which "the average person in the general population" can, for example, care for oneself, perform manual tasks, walk, see, hear, speak, breathe and learn, *see* 29 C.F.R. § 1630.2(i), HIV-positive people are significantly restricted in the most fundamental way imaginable. They die, and they die far earlier than persons who do not suffer from the disability.

That is not to say, however, that every physical impairment that has a demonstrable effect on life expectancy is necessarily a protected disability under the ADA. The terms of the statute cover only those physical impairments that *substantially* limit major life activities. Even with recent advances in treatment, HIV is still an incurable and inevitably fatal condition that substantially limits an infected person's life expectancy compared with that of the general population. Therefore it falls squarely within the statutory definition. Other impairments may or may not rise to that level of severity, depending on their specific circumstances.

HIV-positive children are perhaps most profoundly affected by the inevitably fatal path of the virus. The median survival age of children infected with HIV at birth has been estimated at 8.1 to 10.7 years. *See* Huiman X. Barnhart et al., *Natural History of Human Immunodeficiency Virus Disease in Perinatally Infected Children: An Analysis from the Pediatric Spectrum of Disease Project*, 97 Pediatrics 710 (1996). Thus, while most children and adolescents constantly plan for the future—what sports to play, what schools to attend, where to live and work, with whom to seek relationships—those infected with HIV are hobbled by a strict regimen of medical treatment[25] and by the knowledge that, unless a cure is found

[25] In addition to the limitation of the duration of life expectancy, the condition of the life of an HIV-infected child who is receiving antiretroviral therapy may also be substantially limited when compared to the general population. The recommended drugs for HIV can cause side effects such as pancreatitis, rash, headache, nausea, and fever. *See* F.M. Balis & David Poplack, *Drug Development and Clinical Pharmacology of Antiretroviral Drugs*, *in* Pediatric AIDS: The Challenge of HIV Infection in Infants, Children, and Adolescents 638 (Philip A. Pizzo, M.D. & Catherine

before they die, they will almost certainly not grow to adulthood, complete their schooling, have a career, or have children and grandchildren. Their ability to plan, to play, to go to school, to form intimate relationships, to travel, and to live the life of a normal child or adolescent is first restricted, and then eliminated altogether, by their disease.[26]

To hold that it is legal to discriminate against HIV-positive children on the basis of their physical condition is not only illogical; it is unfair. HIV infection does not distinguish among children and adults, fertile or infertile people, homosexuals or heterosexuals. It affects everyone in the same way. If only a narrow subset of those infected with HIV is considered "disabled" within the definition of the ADA, HIV-positive children, among others, will be unprotected from discrimination. Congress, which had the plight of these children well in mind when it passed the Act, did not intend the ADA to be applied so parsimoniously.

CONCLUSION

As noted above, one of the first reported cases involving HIV discrimination held that an HIV-positive child was a protected individual. *See supra* at 12-13. Although great advances have been made in treatment since that time, several things are unchanged. HIV infection is still fatal; hundreds of children are infected each year; and discrimination against people with HIV and AIDS persists in all areas of public life. This Court should affirm the judgment below, and make clear

---

M. Wilfert, M.D. eds., 2d ed. 1994). Such side effects can be anticipated to limit the condition within which a child can perform many major life activities.

[26] *See Be A Friend: Children Who Live With HIV Speak* (Lori S. Weiner et al. eds., 1994) at 11 ("I often wonder how much longer in life I have. Sometimes I think I only have months to live. Other times I'm more hopeful, and I think I'll live at least a couple more years."); *id.* at 13 ("[I]f I didn't have AIDS * * * I would not have to get up at 11 pm or at 7 am to take medicine"); *id.* at 18 ("Being normal is not worrying every day about if and when you will get sick and about how people will treat you at that time. I would do anything so that I could be normal.")

that *all* individuals with HIV, whether exhibiting outward symptoms or not, children or adults, are deserving of and entitled to the protections of the ADA. The ADA was passed, in no small part, for them.

Respectfully submitted,

ALTHEA GREGORY
5500 Friendship Blvd.
Chevy Chase, MD 20815
(301) 951-3602

LYNN E. CUNNINGHAM*
Associate Professor of
Clinical Law
The Jacob Burns Community
Legal Clinics
The George Washington
University Law School
2000 G Street, N.W.
Suite 200
Washington, D.C. 20052
(202) 994-7463

* Counsel of Record

Counsel for Amicus Curiae